

AMENDMENT IN THE NATURE OF A SUBSTITUTE
TO H.R. 4157, AS REPORTED
OFFERED BY M .

Strike all after the enacting clause and insert the following:

1 SECTION 1. SHORT TITLE AND TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the
“Health Information Technology Promotion Act of 2006”.

4 (b) TABLE OF CONTENTS.—The table of contents of
5 this Act is as follows:

Sec. 1. Short title and table of contents.

Sec. 2. Preserving privacy and security laws.

TITLE I—COORDINATION FOR, PLANNING FOR, AND
INTEROPERABILITY OF HEALTH INFORMATION TECHNOLOGY

Sec. 101. Office of the National Coordinator for Health Information Technology.

Sec. 102. Report on the American Health Information Community.

Sec. 103. Interoperability planning process; Federal information collection activities.

Sec. 104. Grants to integrated health systems to promote health information technologies to improve coordination of care for the uninsured, underinsured, and medically underserved.

Sec. 105. Small physician practice demonstration grants.

TITLE II—TRANSACTION STANDARDS, CODES, AND INFORMATION

Sec. 201. Procedures to ensure timely updating of standards that enable electronic exchanges.

Sec. 202. Upgrading ASC X12 and NCPDP standards.

Sec. 203. Upgrading ICD codes; coding and documentation of non-medical information.

Sec. 204. Strategic plan for coordinating implementation of transaction standards and ICD codes.

Sec. 205. Study and report to determine impact of variation and commonality in State health information laws and regulations.

TITLE III—PROMOTING THE USE OF HEALTH INFORMATION
TECHNOLOGY TO BETTER COORDINATE HEALTH CARE

- Sec. 301. Safe harbors to antikickback civil penalties and criminal penalties for provision of health information technology and training services.
- Sec. 302. Exception to limitation on certain physician referrals (under Stark) for provision of health information technology and training services to health care professionals.
- Sec. 303. Rules of construction regarding use of consortia.

TITLE IV—ADDITIONAL PROVISIONS

- Sec. 401. Promotion of telehealth services.
- Sec. 402. Study and report on expansion of home health-related telehealth services.
- Sec. 403. Study and report on store and forward technology for telehealth.
- Sec. 404. Methodology for reporting uniform price data for inpatient and outpatient hospital services.
- Sec. 405. Inclusion of uniform price data.
- Sec. 406. Ensuring health care providers participating in PHSA programs, Medicaid, SCHIP, or the MCH program may maintain health information in electronic form.
- Sec. 407. Ensuring health care providers participating in the Medicare program may maintain health information in electronic form.
- Sec. 408. Study and report on State, regional, and community health information exchanges.

1 SEC. 2. PRESERVING PRIVACY AND SECURITY LAWS.

2 Nothing in this Act (or the amendments made by this
3 Act) shall be construed to affect the scope, substance, or
4 applicability of section 264(c) of the Health Insurance
5 Portability and Accountability Act of 1996 and any regu-
6 lation issued pursuant to such section.

1 **TITLE I—COORDINATION FOR,**
2 **PLANNING FOR, AND INTER-**
3 **OPERABILITY OF HEALTH IN-**
4 **FORMATION TECHNOLOGY**

5 **SEC. 101. OFFICE OF THE NATIONAL COORDINATOR FOR**
6 **HEALTH INFORMATION TECHNOLOGY.**

7 (a) IN GENERAL.—Title II of the Public Health Serv-
8 ice Act is amended by adding at the end the following new
9 part:

10 **“PART D—HEALTH INFORMATION TECHNOLOGY**
11 **“SEC. 271. OFFICE OF THE NATIONAL COORDINATOR FOR**
12 **HEALTH INFORMATION TECHNOLOGY.**

13 “(a) ESTABLISHMENT.—There is established within
14 the Department of Health and Human Services an Office
15 of the National Coordinator for Health Information Tech-
16 nology that shall be headed by the National Coordinator
17 for Health Information Technology (referred to in this
18 part as the ‘National Coordinator’). The National Coordi-
19 nator shall be appointed by and report directly to the Sec-
20 retary. The National Coordinator shall be paid at a rate
21 equal to the rate of basic pay for level IV of the Executive
22 Schedule.

23 “(b) GOALS OF NATIONWIDE INTEROPERABLE
24 HEALTH INFORMATION TECHNOLOGY INFRASTRUC-
25 TURE.—The National Coordinator shall perform the du-

1 ties under subsection (c) in a manner consistent with the
2 development of a nationwide interoperable health informa-
3 tion technology infrastructure that—

4 “(1) improves health care quality, promotes
5 data accuracy, reduces medical errors, increases the
6 efficiency of care, and advances the delivery of ap-
7 propriate, evidence-based health care services;

8 “(2) promotes wellness, disease prevention, and
9 management of chronic illnesses by increasing the
10 availability and transparency of information related
11 to the health care needs of an individual for such in-
12 dividual;

13 “(3) promotes the availability of appropriate
14 and accurate information necessary to make medical
15 decisions in a usable form at the time and in the lo-
16 cation that the medical service involved is provided;

17 “(4) produces greater value for health care ex-
18 penditures by reducing health care costs that result
19 from inefficiency, medical errors, inappropriate care,
20 and incomplete or inaccurate information;

21 “(5) promotes a more effective marketplace,
22 greater competition, greater systems analysis, in-
23 creased consumer choice, enhanced quality, and im-
24 proved outcomes in health care services;

1 “(6) with respect to health information of con-
2 sumers, advances the portability of such information
3 and the ability of such consumers to share and use
4 such information to assist in the management of
5 their health care;

6 “(7) improves the coordination of information
7 and the provision of such services through an effec-
8 tive infrastructure for the secure and authorized ex-
9 change and use of health care information;

10 “(8) is consistent with legally applicable re-
11 quirements with respect to securing and protecting
12 the confidentiality of individually identifiable health
13 information of a patient;

14 “(9) promotes the creation and maintenance of
15 transportable, secure, Internet-based personal health
16 records, including promoting the efforts of health
17 care payers and health plan administrators for a
18 health plan, such as Federal agencies, private health
19 plans, and third party administrators, to provide for
20 such records on behalf of members of such a plan;

21 “(10) promotes access to and review of the elec-
22 tronic health record of a patient by such patient;

23 “(11) promotes health research and health care
24 quality research and assessment; and

1 “(12) promotes the efficient and streamlined
2 development, submission, and maintenance of elec-
3 tronic health care clinical trial data.

4 “(c) DUTIES OF THE NATIONAL COORDINATOR.—

5 “(1) STRATEGIC PLANNER FOR INTEROPER-
6 ABLE HEALTH INFORMATION TECHNOLOGY.—The
7 National Coordinator shall provide for a strategic
8 plan for the nationwide implementation of interoper-
9 able health information technology in both the public
10 and private health care sectors consistent with sub-
11 section (b).

12 “(2) PRINCIPAL ADVISOR TO THE SEC-
13 RETARY.—The National Coordinator shall serve as
14 the principal advisor to the Secretary on the develop-
15 ment, application, and use of health information
16 technology, and shall coordinate the policies and pro-
17 grams of the Department of Health and Human
18 Services for promoting the use of health information
19 technology.

20 “(3) INTRAGOVERNMENTAL COORDINATOR.—
21 The National Coordinator shall ensure that health
22 information technology policies and programs of the
23 Department of Health and Human Services are co-
24 ordinated with those of relevant executive branch
25 agencies and departments with a goal to avoid dupli-

1 cation of effort, to align the health information ar-
2 chitecture of each agency or department toward a
3 common approach, to ensure that each agency or de-
4 partment conducts programs within the areas of its
5 greatest expertise and its mission in order to create
6 a national interoperable health information system
7 capable of meeting national public health needs ef-
8 fectively and efficiently, and to assist Federal agen-
9 cies and departments in security programs, policies,
10 and protections to prevent unauthorized access to in-
11 dividually identifiable health information created,
12 maintained, or in the temporary possession of that
13 agency or department. The coordination authority
14 provided to the National Coordinator under the pre-
15 vious sentence shall supercede any such authority
16 otherwise provided to any other official of the De-
17 partment of Health and Human Services. For the
18 purposes of this paragraph, the term ‘unauthorized
19 access’ means access that is not authorized by that
20 agency or department including unauthorized em-
21 ployee access.

22 “(4) ADVISOR TO OMB.—The National Coordi-
23 nator shall provide to the Director of the Office of
24 Management and Budget comments and advice with

1 respect to specific Federal health information tech-
2 nology programs.

3 “(5) PROMOTER OF HEALTH INFORMATION
4 TECHNOLOGY IN MEDICALLY UNDERSERVED COMMU-
5 NITIES.—The National Coordinator shall—

6 “(A) identify sources of funds that will be
7 made available to promote and support the
8 planning and adoption of health information
9 technology in medically underserved commu-
10 nities, including in urban and rural areas, ei-
11 ther through grants or technical assistance;

12 “(B) coordinate with the funding sources
13 to help such communities connect to identified
14 funding; and

15 “(C) collaborate with the Agency for
16 Healthcare Research and Quality and the
17 Health Services Resources Administration and
18 other Federal agencies to support technical as-
19 sistance, knowledge dissemination, and resource
20 development, to medically underserved commu-
21 nities seeking to plan for and adopt technology
22 and establish electronic health information net-
23 works across providers.”.

1 (b) TREATMENT OF EXECUTIVE ORDER 13335.—Ex-
2 ecutive Order 13335 shall not have any force or effect
3 after the date of the enactment of this Act.

4 (c) TRANSITION FROM ONCHIT UNDER EXECUTIVE
5 ORDER.—

6 (1) IN GENERAL.—All functions, personnel, as-
7 sets, liabilities, administrative actions, and statutory
8 reporting requirements applicable to the old Na-
9 tional Coordinator or the Office of the old National
10 Coordinator on the date before the date of the enact-
11 ment of this Act shall be transferred, and applied in
12 the same manner and under the same terms and
13 conditions, to the new National Coordinator and the
14 Office of the new National Coordinator as of the
15 date of the enactment of this Act.

16 (2) RULE OF CONSTRUCTION.— Nothing in this
17 section or the amendment made by this section shall
18 be construed as requiring the duplication of Federal
19 efforts with respect to the establishment of the Of-
20 fice of the National Coordinator for Health Informa-
21 tion Technology, regardless of whether such efforts
22 are carried out before or after the date of the enact-
23 ment of this Act.

24 (3) ACTING NATIONAL COORDINATOR.—Before
25 the appointment of the new National Coordinator,

1 the old National Coordinator shall act as the Na-
2 tional Coordinator for Health Information Tech-
3 nology until the office is filled as provided in section
4 271(a) of the Public Health Service Act, as added
5 by subsection (a). The Secretary of Health and
6 Human Services may appoint the old National Coor-
7 dinator as the new National Coordinator.

8 (4) DEFINITIONS.—For purposes of this sub-
9 section:

10 (A) NEW NATIONAL COORDINATOR.—The
11 term “new National Coordinator” means the
12 National Coordinator for Health Information
13 Technology appointed under section 271(a) of
14 the Public Health Service Act, as added by sub-
15 section (a).

16 (B) OLD NATIONAL COORDINATOR.—The
17 term “old National Coordinator” means the
18 National Coordinator for Health Information
19 Technology appointed under Executive Order
20 13335.

21 **SEC. 102. REPORT ON THE AMERICAN HEALTH INFORMA-**
22 **TION COMMUNITY.**

23 Not later than one year after the date of the enact-
24 ment of this Act, the Secretary of Health and Human
25 Services shall submit to Congress a report on the work

1 conducted by the American Health Information Commu-
2 nity (in this section referred to as “AHIC”), as established
3 by the Secretary. Such report shall include the following:

4 (1) A description of the accomplishments of
5 AHIC, with respect to the promotion of the develop-
6 ment of national guidelines, the development of a
7 nationwide health information network, and the in-
8 creased adoption of health information technology.

9 (2) Information on how model privacy and secu-
10 rity policies may be used to protect confidentiality of
11 health information, and an assessment of how exist-
12 ing policies compare to such model policies.

13 (3) Information on the progress in—

14 (A) establishing uniform industry-wide
15 health information technology standards;

16 (B) achieving an internet-based nationwide
17 health information network;

18 (C) achieving interoperable electronic
19 health record adoption across health care pro-
20 viders; and

21 (D) creating technological innovations to
22 promote security and confidentiality of individ-
23 ually identifiable health information.

1 (4) Recommendations for the transition of
2 AHIC to a longer-term or permanent advisory and
3 facilitation entity, including—

4 (A) a schedule for such transition;

5 (B) options for structuring the entity as ei-
6 ther a public-private or private sector entity;

7 (C) the collaborative role of the Federal
8 Government in the entity;

9 (D) steps for—

10 (i) continued leadership in the facilita-
11 tion of guidelines or standards;

12 (ii) the alignment of financial incen-
13 tives; and

14 (iii) the long-term plan for health care
15 transformation through information tech-
16 nology; and

17 (E) the elimination or revision of the func-
18 tions of AHIC during the development of the
19 nationwide health information network.

20 **SEC. 103. INTEROPERABILITY PLANNING PROCESS; FED-**
21 **ERAL INFORMATION COLLECTION ACTIVI-**
22 **TIES.**

23 Part D of title II of the Public Health Service Act,
24 as added by section 101(a), is amended by adding at the
25 end the following new section:

1 **“SEC. 272. INTEROPERABILITY PLANNING PROCESS; FED-**
2 **ERAL INFORMATION COLLECTION ACTIVI-**
3 **TIES.**

4 “(a) STRATEGIC INTEROPERABILITY PLANNING
5 PROCESS.—

6 “(1) ASSESSMENT AND ENDORSEMENT OF
7 CORE STRATEGIC GUIDELINES.—

8 “(A) IN GENERAL.—Not later than De-
9 cember 31, 2006, the National Coordinator
10 shall publish a strategic plan, including a sched-
11 ule, for the assessment and the endorsement of
12 core interoperability guidelines for significant
13 use cases consistent with this subsection. The
14 National Coordinator may update such plan
15 from time to time.

16 “(B) ENDORSEMENT.—

17 “(i) IN GENERAL.—Consistent with
18 the schedule under this paragraph and not
19 later than one year after the publication of
20 such schedule, the National Coordinator
21 shall endorse a subset of core interoper-
22 ability guidelines for significant use cases.
23 The National Coordinator shall continue to
24 endorse subsets of core interoperability
25 guidelines for significant use cases annu-
26 ally consistent with the schedule published

1 pursuant to this paragraph, with endorse-
2 ment of all such guidelines completed not
3 later than August 31, 2009.

4 “(ii) CONSULTATION.—All such en-
5 dorsements shall be in consultation with
6 the American Health Information Commu-
7 nity and other appropriate entities.

8 “(iii) VOLUNTARY COMPLIANCE.—
9 Compliance with such guidelines shall be
10 voluntary, subject to subsection (b)(1).

11 “(C) CONSULTATION WITH OTHER PAR-
12 TIES.—The National Coordinator shall develop
13 and implement such strategic plan in consulta-
14 tion with the American Health Information
15 Community and other appropriate entities.

16 “(D) DEFINITIONS.—For purposes of this
17 section:

18 “(i) INTEROPERABILITY GUIDE-
19 LINE.—The term ‘interoperability guide-
20 line’ means a guideline to improve and pro-
21 mote the interoperability of health infor-
22 mation technology for purposes of elec-
23 tronically accessing and exchanging health
24 information. Such term includes named
25 standards, architectures, software schemes

1 for identification, authentication, and secu-
2 rity, and other information needed to en-
3 sure the reproducible development of com-
4 mon solutions across disparate entities.

5 “(ii) CORE INTEROPERABILITY GUIDE-
6 LINE.—The term ‘core interoperability
7 guideline’ means an interoperability guide-
8 line that the National Coordinator deter-
9 mines is essential and necessary for pur-
10 poses described in clause (i).

11 “(iii) SIGNIFICANT USE CASE.—The
12 term ‘significant use case’ means a cat-
13 egory (as specified by the National Coordi-
14 nator) that identifies a significant use or
15 purpose for the interoperability of health
16 information technology, such as for the ex-
17 change of laboratory information, drug
18 prescribing, clinical research, and elec-
19 tronic health records.

20 “(2) NATIONAL SURVEY.—

21 “(A) IN GENERAL.—Not later than August
22 31, 2008, the National Coordinator shall con-
23 duct one or more surveys designed to measure
24 the capability of entities (including Federal
25 agencies, State and local government agencies,

1 and private sector entities) to exchange elec-
2 tronic health information by appropriate signifi-
3 cant use case. Such surveys shall identify the
4 extent to which the type of health information,
5 the use for such information, or any other ap-
6 propriate characterization of such information
7 may relate to the capability of such entities to
8 exchange health information in a manner that
9 is consistent with methods to improve the inter-
10 operability of health information and with core
11 interoperability guidelines.

12 “(B) DISSEMINATION OF SURVEY RE-
13 SULTS.—The National Coordinator shall dis-
14 seminate the results of such surveys in a man-
15 ner so as to—

16 “(i) inform the public on the capabili-
17 ties of entities to exchange electronic
18 health information;

19 “(ii) assist in establishing a more
20 interoperable information architecture; and

21 “(iii) identify the status of health in-
22 formation systems used in Federal agen-
23 cies and the status of such systems with
24 respect to interoperability guidelines.

1 “(b) FEDERAL HEALTH INFORMATION COLLECTION
2 ACTIVITIES.—

3 “(1) REQUIREMENTS.—With respect to a core
4 interoperability guideline endorsed under subsection
5 (a)(1)(B) for a significant use case, the President
6 shall take measures to ensure that Federal activities
7 involving the broad collection and submission of
8 health information are consistent with such guideline
9 within three years after the date of such endorse-
10 ment.

11 “(2) PROMOTING USE OF NON-IDENTIFIABLE
12 HEALTH INFORMATION TO IMPROVE HEALTH RE-
13 SEARCH AND HEALTH CARE QUALITY.—

14 “(A) IN GENERAL.—Where feasible, and
15 consistent with applicable privacy or security or
16 other laws, the President, in consultation with
17 the Secretary, shall take measures to allow
18 timely access to useful categories of non-identi-
19 fiable health information in records maintained
20 by the Federal government, or maintained by
21 entities under contract with the Federal govern-
22 ment, to advance health care quality and health
23 research where such information is in a form
24 that can be used in such research. The Presi-
25 dent shall consult with appropriate Federal

1 agencies, and solicit public comment, on useful
2 categories of information, and appropriate
3 measures to take. The President may consider
4 the administrative burden and the potential for
5 improvements in health care quality in deter-
6 mining such appropriate measures. In addition,
7 the President, in consultation with the Sec-
8 retary, shall encourage voluntary private and
9 public sector efforts to allow access to such use-
10 ful categories of non-identifiable health infor-
11 mation to advance health care quality and
12 health research.

13 “(B) NON-IDENTIFIABLE HEALTH INFOR-
14 MATION DEFINED.—For purposes of this para-
15 graph, the term ‘non-identifiable health infor-
16 mation’ means information that is not individ-
17 ually identifiable health information as defined
18 in rules promulgated pursuant to section 264(c)
19 of the Health Insurance Portability and Ac-
20 countability Act of 1996 (42 U.S.C. 1320d-2
21 note), and includes information that has been
22 de-identified so that it is no longer individually
23 identifiable health information, as defined in
24 such rules.

1 “(3) ANNUAL REVIEW AND REPORT.—For each
2 year during the five-year period following the date of
3 the enactment of this section, the National Coordi-
4 nator shall review the operation of health informa-
5 tion collection by and submission to the Federal gov-
6 ernment and the purchases (and planned purchases)
7 of health information technology by the Federal gov-
8 ernment. For each such year and based on the re-
9 view for such year, the National Coordinator shall
10 submit to the President and Congress recommenda-
11 tions on methods to—

12 “(A) streamline (and eliminate redundancy
13 in) Federal systems used for the collection and
14 submission of health information;

15 “(B) improve efficiency in such collection
16 and submission;

17 “(C) increase the ability to assess health
18 care quality; and

19 “(D) reduce health care costs.”.

1 **SEC. 104. GRANTS TO INTEGRATED HEALTH SYSTEMS TO**
2 **PROMOTE HEALTH INFORMATION TECH-**
3 **NOLOGIES TO IMPROVE COORDINATION OF**
4 **CARE FOR THE UNINSURED, UNDERINSURED,**
5 **AND MEDICALLY UNDERSERVED.**

6 Subpart I of part D of title III of the Public Health
7 Service Act (42 U.S.C. 254b et seq.) is amended by adding
8 at the end the following:

9 **“SEC. 330M. GRANTS FOR IMPROVEMENT OF THE COORDI-**
10 **NATION OF CARE FOR THE UNINSURED,**
11 **UNDERINSURED, AND MEDICALLY UNDER-**
12 **SERVED.**

13 “(a) IN GENERAL.—The Secretary may make grants
14 to integrated health care systems, in accordance with this
15 section, for projects to better coordinate the provision of
16 health care through the adoption of new health informa-
17 tion technology, or the significant improvement of existing
18 health information technology, to improve the provision of
19 health care to uninsured, underinsured, and medically un-
20 derserved individuals (including in urban and rural areas)
21 through health-related information about such individuals,
22 throughout such a system and at the point of service.

23 “(b) ELIGIBILITY.—

24 “(1) APPLICATION.—To be eligible to receive a
25 grant under this section, an integrated health care
26 system shall prepare and submit to the Secretary an

1 application, at such time, in such manner, and con-
2 taining such information as the Secretary may re-
3 quire, including—

4 “(A) a description of the project that the
5 system will carry out using the funds provided
6 under the grant;

7 “(B) a description of the manner in which
8 the project funded under the grant will advance
9 the goal specified in subsection (a); and

10 “(C) a description of the populations to be
11 served by the adoption or improvement of
12 health information technology.

13 “(2) OPTIONAL REPORTING CONDITION.—The
14 Secretary may also condition the provision of a
15 grant to an integrated health care system under this
16 section for a project on the submission by such sys-
17 tem to the Secretary of a report on the impact of
18 the health information technology adopted (or im-
19 proved) under such project on the delivery of health
20 care and the quality of care (in accordance with ap-
21 plicable measures of such quality). Such report shall
22 be at such time and in such form and manner as
23 specified by the Secretary.

24 “(c) INTEGRATED HEALTH CARE SYSTEM DE-
25 FINED.—For purposes of this section, the term ‘integrated

1 health care system’ means a system of health care pro-
2 viders that is organized to provide care in a coordinated
3 fashion and has a demonstrated commitment to provide
4 uninsured, underinsured, and medically underserved indi-
5 viduals with access to such care.

6 “(d) PRIORITIES.—In making grants under this sec-
7 tion, the Secretary shall give priority to an integrated
8 health care system—

9 “(1) that can demonstrate past successful com-
10 munity-wide efforts to improve the quality of care
11 provided and the coordination of care for the unin-
12 sured, underinsured, and medically underserved; or

13 “(2) if the project to be funded through such a
14 grant—

15 “(A) will improve the delivery of health
16 care and the quality of care provided; and

17 “(B) will demonstrate savings for State or
18 Federal health care benefits programs or enti-
19 ties legally obligated under Federal law to pro-
20 vide health care from the reduction of duplica-
21 tive health care services, administrative costs,
22 and medical errors.

23 “(e) LIMITATION, MATCHING REQUIREMENT, AND
24 CONDITIONS.—

1 “(1) LIMITATION ON USE OF FUNDS.—None of
2 the funds provided under a grant made under this
3 section may be used for a project providing for the
4 adoption or improvement of health information tech-
5 nology that is used exclusively for financial record
6 keeping, billing, or other non-clinical applications.

7 “(2) MATCHING REQUIREMENT.—To be eligible
8 for a grant under this section an integrated health
9 care system shall contribute non-Federal contribu-
10 tions to the costs of carrying out the project for
11 which the grant is awarded in an amount equal to
12 \$1 for each \$5 of Federal funds provided under the
13 grant.

14 “(f) AUTHORIZATION OF APPROPRIATIONS.—There
15 are authorized to be appropriated to carry out this section
16 \$15,000,000 for each of fiscal years 2007 and 2008.”.

17 **SEC. 105. SMALL PHYSICIAN PRACTICE DEMONSTRATION**
18 **GRANTS.**

19 Part D of title II of the Public Health Service Act,
20 as added by section 101(a) and amended by section 103,
21 is amended by adding at the end the following new section:

22 **“SEC. 273. SMALL PHYSICIAN PRACTICE DEMONSTRATION**
23 **GRANTS.**

24 “(a) IN GENERAL.—The Secretary shall establish a
25 demonstration program under which the Secretary makes

1 grants to small physician practices (including such prac-
2 tices that furnish services to individuals with chronic ill-
3 nesses) that are located in rural areas or medically under-
4 served urban areas for the purchase and support of health
5 information technology.

6 “(b) ELIGIBILITY.—To be eligible to receive a grant
7 under this section, an applicant shall prepare and submit
8 to the Secretary an application, at such time, in such man-
9 ner, and containing such information, as the Secretary
10 may require.

11 “(c) REPORTING.—

12 “(1) REQUIRED REPORTS BY SMALL PHYSICIAN
13 PRACTICES.—A small physician practice receiving a
14 grant under subsection (a) shall submit to the Sec-
15 retary an evaluation on the health information tech-
16 nology funded by such grant. Such evaluation shall
17 include information on—

18 “(A) barriers to the adoption of health in-
19 formation technology by the small physician
20 practice;

21 “(B) issues for such practice in the use of
22 health information technology;

23 “(C) the effect health information tech-
24 nology will have on the quality of health care
25 furnished by such practice; and

1 “(D) the effect of any medical liability
2 rules on such practice.

3 “(2) REPORT TO CONGRESS.—Not later than
4 January 1, 2009, the Secretary shall submit to Con-
5 gress a report on the results of the demonstration
6 program under this section.

7 “(d) AUTHORIZATION OF APPROPRIATIONS.—There
8 are authorized to be appropriated to carry out this section
9 \$5,000,000 for each of fiscal years 2007 and 2008.”.

10 **TITLE II—TRANSACTION STAND-**
11 **ARDS, CODES, AND INFORMA-**
12 **TION**

13 **SEC. 201. PROCEDURES TO ENSURE TIMELY UPDATING OF**
14 **STANDARDS THAT ENABLE ELECTRONIC EX-**
15 **CHANGES.**

16 Section 1174(b) of the Social Security Act (42 U.S.C.
17 1320d-3(b)) is amended—

18 (1) in paragraph (1)—

19 (A) in the first sentence, by inserting “and
20 in accordance with paragraph (3)” before the
21 period; and

22 (B) by adding at the end the following new
23 sentence: “For purposes of this subsection and
24 section 1173(c)(2), the term ‘modification’ in-

1 cludes a new version or a version upgrade.”;

2 and

3 (2) by adding at the end the following new

4 paragraph:

5 “(3) EXPEDITED PROCEDURES FOR ADOPTION

6 OF ADDITIONS AND MODIFICATIONS TO STAND-

7 ARDS.—

8 “(A) IN GENERAL.—For purposes of para-

9 graph (1), the Secretary shall provide for an ex-

10 pedited upgrade program (in this paragraph re-

11 ferred to as the ‘upgrade program’), in accord-

12 ance with this paragraph, to develop and ap-

13 prove additions and modifications to the stand-

14 ards adopted under section 1173(a) to improve

15 the quality of such standards or to extend the

16 functionality of such standards to meet evolving

17 requirements in health care.

18 “(B) PUBLICATION OF NOTICES.—Under

19 the upgrade program:

20 “(i) VOLUNTARY NOTICE OF INITI-

21 ATION OF PROCESS.—Not later than 30

22 days after the date the Secretary receives

23 a notice from a standard setting organiza-

24 tion that the organization is initiating a

25 process to develop an addition or modifica-

1 tion to a standard adopted under section
2 1173(a), the Secretary shall publish a no-
3 tice in the Federal Register that—

4 “(I) identifies the subject matter
5 of the addition or modification;

6 “(II) provides a description of
7 how persons may participate in the
8 development process; and

9 “(III) invites public participation
10 in such process.

11 “(ii) VOLUNTARY NOTICE OF PRE-
12 LIMINARY DRAFT OF ADDITIONS OR MODI-
13 FICATIONS TO STANDARDS.—Not later
14 than 30 days after the date of the date the
15 Secretary receives a notice from a standard
16 setting organization that the organization
17 has prepared a preliminary draft of an ad-
18 dition or modification to a standard adopt-
19 ed by section 1173(a), the Secretary shall
20 publish a notice in the Federal Register
21 that—

22 “(I) identifies the subject matter
23 of (and summarizes) the addition or
24 modification;

1 “(II) specifies the procedure for
2 obtaining the draft;

3 “(III) provides a description of
4 how persons may submit comments in
5 writing and at any public hearing or
6 meeting held by the organization on
7 the addition or modification; and

8 “(IV) invites submission of such
9 comments and participation in such
10 hearing or meeting without requiring
11 the public to pay a fee to participate.

12 “(iii) NOTICE OF PROPOSED ADDITION
13 OR MODIFICATION TO STANDARDS.—Not
14 later than 30 days after the date of the
15 date the Secretary receives a notice from a
16 standard setting organization that the or-
17 ganization has a proposed addition or
18 modification to a standard adopted under
19 section 1173(a) that the organization in-
20 tends to submit under subparagraph
21 (D)(iii), the Secretary shall publish a no-
22 tice in the Federal Register that contains,
23 with respect to the proposed addition or
24 modification, the information required in

1 the notice under clause (ii) with respect to
2 the addition or modification.

3 “(iv) CONSTRUCTION.—Nothing in
4 this paragraph shall be construed as re-
5 quiring a standard setting organization to
6 request the notices described in clauses (i)
7 and (ii) with respect to an addition or
8 modification to a standard in order to
9 qualify for an expedited determination
10 under subparagraph (C) with respect to a
11 proposal submitted to the Secretary for
12 adoption of such addition or modification.

13 “(C) PROVISION OF EXPEDITED DETER-
14 MINATION.—Under the upgrade program and
15 with respect to a proposal by a standard setting
16 organization for an addition or modification to
17 a standard adopted under section 1173(a), if
18 the Secretary determines that the standard set-
19 ting organization developed such addition or
20 modification in accordance with the require-
21 ments of subparagraph (D) and the National
22 Committee on Vital and Health Statistics rec-
23 ommends approval of such addition or modifica-
24 tion under subparagraph (E), the Secretary

1 shall provide for expedited treatment of such
2 proposal in accordance with subparagraph (F).

3 “(D) REQUIREMENTS.—The requirements
4 under this subparagraph with respect to a pro-
5 posed addition or modification to a standard by
6 a standard setting organization are the fol-
7 lowing:

8 “(i) REQUEST FOR PUBLICATION OF
9 NOTICE.—The standard setting organiza-
10 tion submits to the Secretary a request for
11 publication in the Federal Register of a no-
12 tice described in subparagraph (B)(iii) for
13 the proposed addition or modification.

14 “(ii) PROCESS FOR RECEIPT AND
15 CONSIDERATION OF PUBLIC COMMENT.—
16 The standard setting organization provides
17 for a process through which, after the pub-
18 lication of the notice referred to under
19 clause (i), the organization—

20 “(I) receives and responds to
21 public comments submitted on a time-
22 ly basis on the proposed addition or
23 modification before submitting such
24 proposed addition or modification to

1 the National Committee on Vital and
2 Health Statistics under clause (iii);

3 “(II) makes publicly available a
4 written explanation for its response in
5 the proposed addition or modification
6 to comments submitted on a timely
7 basis; and

8 “(III) makes public comments re-
9 ceived under clause (I) available, or
10 provides access to such comments, to
11 the Secretary.

12 “(iii) SUBMITTAL OF FINAL PRO-
13 POSED ADDITION OR MODIFICATION TO
14 NCVHS.—After completion of the process
15 under clause (ii), the standard setting or-
16 ganization submits the proposed addition
17 or modification to the National Committee
18 on Vital and Health Statistics for review
19 and consideration under subparagraph (E).
20 Such submission shall include information
21 on the organization’s compliance with the
22 notice and comment requirements (and re-
23 sponses to those comments) under clause
24 (ii).

1 “(E) HEARING AND RECOMMENDATIONS
2 BY NATIONAL COMMITTEE ON VITAL AND
3 HEALTH STATISTICS.—Under the upgrade pro-
4 gram, upon receipt of a proposal submitted by
5 a standard setting organization under subpara-
6 graph (D)(iii) for the adoption of an addition or
7 modification to a standard, the National Com-
8 mittee on Vital and Health Statistics shall pro-
9 vide notice to the public and a reasonable op-
10 portunity for public testimony at a hearing on
11 such addition or modification. The Secretary
12 may participate in such hearing in such capac-
13 ity (including presiding ex officio) as the Sec-
14 retary shall determine appropriate. Not later
15 than 120 days after the date of receipt of the
16 proposal, the Committee shall submit to the
17 Secretary its recommendation to adopt (or not
18 adopt) the proposed addition or modification.

19 “(F) DETERMINATION BY SECRETARY TO
20 ACCEPT OR REJECT NATIONAL COMMITTEE ON
21 VITAL AND HEALTH STATISTICS RECOMMENDA-
22 TION.—

23 “(i) TIMELY DETERMINATION.—
24 Under the upgrade program, if the Na-
25 tional Committee on Vital and Health Sta-

1 tistics submits to the Secretary a rec-
2 ommendation under subparagraph (E) to
3 adopt a proposed addition or modification,
4 not later than 90 days after the date of re-
5 ceipt of such recommendation the Sec-
6 retary shall make a determination to ac-
7 cept or reject the recommendation and
8 shall publish notice of such determination
9 in the Federal Register not later than 30
10 days after the date of the determination.

11 “(ii) CONTENTS OF NOTICE.—If the
12 determination is to reject the recommenda-
13 tion, such notice shall include the reasons
14 for the rejection. If the determination is to
15 accept the recommendation, as part of
16 such notice the Secretary shall promulgate
17 the modified standard (including the ac-
18 cepted proposed addition or modification
19 accepted) as a final rule under this sub-
20 section without any further notice or public
21 comment period.

22 “(iii) LIMITATION ON CONSIDER-
23 ATION.—The Secretary shall not consider a
24 proposal under this subparagraph unless
25 the Secretary determines that the require-

1 ments of subparagraph (D) (including pub-
2 lication of notice and opportunity for pub-
3 lic comment) have been met with respect to
4 the proposal.

5 “(G) EXEMPTION FROM PAPERWORK RE-
6 DUCTION ACT.—Chapter 35 of title 44, United
7 States Code, shall not apply to a final rule pro-
8 mulgated under subparagraph (F).

9 “(H) TREATMENT AS SATISFYING RE-
10 QUIREMENTS FOR NOTICE-AND-COMMENT.—
11 Any requirements under section 553 of title 5,
12 United States Code, relating to notice and an
13 opportunity for public comment with respect to
14 a final rule promulgated under subparagraph
15 (F) shall be treated as having been met by
16 meeting the requirements of the notice and op-
17 portunity for public comment provided under
18 provisions of subparagraphs (B)(iii), (D), and
19 (E).

20 “(I) NO JUDICIAL REVIEW.—A final rule
21 promulgated under subparagraph (F) shall not
22 be subject to judicial review.”.

23 **SEC. 202. UPGRADING ASC X12 AND NCPDP STANDARDS.**

24 (a) IN GENERAL.—The Secretary of Health and
25 Human Services shall provide by notice published in the

1 Federal Register for the following replacements of stand-
2 ards to apply to transactions occurring on or after April
3 1, 2009:

4 (1) ACCREDITED STANDARDS COMMITTEE X12
5 (ASC X12) STANDARD.—The replacement of the Ac-
6 credited Standards Committee X12 (ASC X12)
7 version 4010 adopted under section 1173(a) of such
8 Act (42 U.S.C. 1320d-2(a)) with the ASC X12
9 version 5010, as reviewed by the National Com-
10 mittee on Vital Health Statistics.

11 (2) NATIONAL COUNCIL FOR PRESCRIPTION
12 DRUG PROGRAMS (NCPDP) TELECOMMUNICATIONS
13 STANDARDS.—The replacement of the National
14 Council for Prescription Drug Programs (NCPDP)
15 Telecommunications Standards version 5.1 adopted
16 under section 1173(a) of such Act (42 U.S.C.
17 1320d-2(a)) with whichever is the latest version of
18 the NCPDP Telecommunications Standards that has
19 been approved by such Council and reviewed by the
20 National Committee on Vital Health Statistics as of
21 April 1, 2007.

22 (b) NO JUDICIAL REVIEW.—The implementation of
23 subsection (a), including the determination of the latest
24 version under subsection (a)(2), shall not be subject to ju-
25 dicial review.

1 **SEC. 203. UPGRADING ICD CODES; CODING AND DOCU-**
2 **MENTATION OF NON-MEDICAL INFORMA-**
3 **TION.**

4 (a) UPGRADING ICD CODES.—

5 (1) IN GENERAL.—The Secretary of Health and
6 Human Services shall provide by notice published in
7 the Federal Register for the replacement of the
8 International Classification of Diseases, 9th revision,
9 Clinical Modification (ICD–9-CM) under the regula-
10 tion promulgated under section 1173(c) of the Social
11 Security Act (42 U.S.C. 1320d-2(c)), including for
12 purposes of part A of title XVIII of such Act, with
13 both of the following:

14 (A) The International Classification of
15 Diseases, 10th revision, Clinical Modification
16 (ICD–10-CM).

17 (B) The International Classification of
18 Diseases, 10th revision, Procedure Coding Sys-
19 tem (ICD–10-PCS).

20 (2) APPLICATION.—The replacement made by
21 paragraph (1) shall apply, for purposes of section
22 1175(b)(2) of the Social Security Act (42 U.S.C.
23 1320d-4(b)(2)), to services furnished on or after Oc-
24 tober 1, 2010.

25 (3) RULES OF CONSTRUCTION.—Nothing in
26 paragraph (1) shall be construed—

1 (A) as affecting the application of classi-
2 fication methodologies or codes, such as CPT or
3 HCPCS codes, other than under the Inter-
4 national Classification of Diseases (ICD); or

5 (B) as superseding the authority of the
6 Secretary of Health and Human Services to
7 maintain and modify the coding set for ICD-
8 10-CM and ICD-10-PCS, including under the
9 amendments made by section 201.

10 (b) CODING AND DOCUMENTATION OF NON-MEDICAL
11 INFORMATION.—In any regulation or other action imple-
12 menting the International Classification of Diseases, 10th
13 revision, Clinical Modification (ICD-10-CM), the Inter-
14 national Classification of Diseases, 10th revision, Proce-
15 dure Coding System (ICD-10-PCS), or other version of
16 the International Classification of Diseases, 10th revision,
17 the Secretary of Health and Human Services shall ensure
18 that no health care provider is required to code to a level
19 of specificity that would require documentation of non-
20 medical information on the external cause of any given
21 type of injury.

1 **SEC. 204. STRATEGIC PLAN FOR COORDINATING IMPE-**
2 **MENTATION OF TRANSACTION STANDARDS**
3 **AND ICD CODES.**

4 Not later than the date that is 180 days after the
5 date of the enactment of this Act, the Secretary of Health
6 and Human Services, in consultation with relevant public
7 and private entities, shall develop a strategic plan with re-
8 spect to the need for coordination in the implementation
9 of—

10 (1) transaction standards under section 1173(a)
11 of the Social Security Act, including modifications to
12 such standards under section 1174(b)(3) of such
13 Act, as added by section 201; and

14 (2) any updated versions of the International
15 Classification of Diseases (ICD), including the re-
16 placement of ICD–9 provided for under section
17 203(a).

18 **SEC. 205. STUDY AND REPORT TO DETERMINE IMPACT OF**
19 **VARIATION AND COMMONALITY IN STATE**
20 **HEALTH INFORMATION LAWS AND REGULA-**
21 **TIONS.**

22 Part C of title XI of the Social Security Act is amend-
23 ed by adding at the end the following new section:

1 “STUDY AND REPORT TO DETERMINE IMPACT OF VARI-
2 ATION AND COMMONALITY IN STATE HEALTH INFOR-
3 MATION LAWS AND REGULATIONS

4 “SEC. 1180. (a) STUDY.—For purposes of promoting
5 the development of a nationwide interoperable health in-
6 formation technology infrastructure consistent with sec-
7 tion 271(b) of the Public Health Service Act, the Sec-
8 retary shall conduct a study of the impact of variation in
9 State security and confidentiality laws and current Fed-
10 eral security and confidentiality standards on the timely
11 exchanges of health information in order to ensure the
12 availability of health information necessary to make med-
13 ical decisions at the location in which the medical care in-
14 volved is provided. Such study shall examine—

15 “(1)(A) the degree of variation and com-
16 monality among the requirements of such laws for
17 States; and

18 “(B) the degree of variation and commonality
19 between the requirements of such laws and the cur-
20 rent Federal standards;

21 “(2) insofar as there is variation among and be-
22 tween such requirements, the strengths and weak-
23 nesses of such requirements; and

24 “(3) the extent to which such variation may ad-
25 versely impact the secure, confidential, and timely

1 exchange of health information among States, the
2 Federal government, and public and private entities,
3 or may otherwise impact the reliability of such infor-
4 mation.

5 “(b) REPORT.—Not later than 18 months after the
6 date of the enactment of this section, the Secretary shall
7 submit to Congress a report on the study under subsection
8 (a) and shall include in such report the following:

9 “(1) ANALYSIS OF NEED FOR GREATER COM-
10 MONALITY.—A determination by the Secretary on
11 the extent to which there is a need for greater com-
12 monality of the requirements of State security and
13 confidentiality laws and current Federal security and
14 confidentiality standards to better protect, strength-
15 en, or otherwise improve the secure, confidential,
16 and timely exchange of health information among
17 States, the Federal government, and public and pri-
18 vate entities.

19 “(2) RECOMMENDATIONS FOR GREATER COM-
20 MONALITY.—Insofar as the Secretary determines
21 under paragraph (1) that there is a need for greater
22 commonality of such requirements, recommendations
23 on the extent to which (and how) the current Fed-
24 eral security and confidentiality standards should be
25 changed in order to provide the commonality needed

1 to better protect, strengthen, or otherwise improve
2 the secure, confidential, and timely exchange of
3 health information.

4 “(3) SPECIFIC RECOMMENDATION ON LEGISLA-
5 TIVE CHANGES FOR GREATER COMMONALITY.—A
6 specific recommendation on the extent to which and
7 how such standards should supersede State laws, in
8 order to provide the commonality needed to better
9 protect or strengthen the security and confidentiality
10 of health information in the timely exchange of such
11 information and legislative language in the form of
12 a bill to effectuate such specific recommendation.

13 “(c) CONGRESSIONAL CONSIDERATION OF LEGISLA-
14 TION PROVIDING FOR GREATER COMMONALITY.—

15 “(1) RULES OF HOUSE OF REPRESENTATIVES
16 AND SENATE.—This subsection is enacted by the
17 Congress—

18 “(A) as an exercise of the rulemaking
19 power of the House of Representatives and the
20 Senate, respectively, and as such they are
21 deemed a part of the rules of each House, re-
22 spectively, but applicable only with respect to
23 the procedure to be followed in that House in
24 the case of a greater commonality bill defined
25 in paragraph (4), and they supersede other

1 rules only to the extent that they are incon-
2 sistent therewith; and

3 “(B) with full recognition of the constitu-
4 tional right of either House to change the rules
5 (so far as relating to the procedure of that
6 House) at any time, in the same manner and
7 to the same extent as in the case of any other
8 rule of that House.

9 “(2) INTRODUCTION.—On the date on which
10 the final report is submitted under subsection
11 (b)(3)—

12 “(A) a greater commonality bill shall be in-
13 troduced (by request) in the House by the ma-
14 jority leader of the House, for himself and the
15 minority leader of the House, or by Members of
16 the House designated by the majority leader
17 and minority leader of the House; and

18 “(B) a greater commonality bill shall be
19 introduced (by request) in the Senate by the
20 majority leader of the Senate, for himself and
21 the minority leader of the Senate, or by Mem-
22 bers of the Senate designated by the majority
23 leader and minority leader of the Senate.

24 If either House is not in session on the day on which
25 such a report is submitted, the greater commonality

1 bill shall be introduced in that House, as provided
2 in the preceding sentence, on the first day thereafter
3 on which the House is in session.

4 “(3) REFERRAL.—A greater commonality bill
5 shall be referred by the Presiding Officers of the re-
6 spective House to the appropriate committee (or
7 committees) of such House, in accordance with the
8 rules of that House.

9 “(4) GREATER COMMONALITY BILL DEFINED.—
10 For purposes of this section, the term ‘greater com-
11 monality bill’ means a bill—

12 “(A) the title of which is the following: ‘A
13 Bill to provide the commonality needed to bet-
14 ter protect, strengthen, or otherwise improve
15 the secure, confidential, and timely exchange of
16 health information’; and

17 “(B) the text of which, as introduced, con-
18 sists of the text of the bill included in the re-
19 port submitted under subsection (b)(3).

20 “(d) DEFINITIONS.—For purposes of this section:

21 “(1) CURRENT FEDERAL SECURITY AND CON-
22 FIDENTIALITY STANDARDS.—The term ‘current Fed-
23 eral security and confidentiality standards’ means
24 the Federal privacy standards established pursuant
25 to section 264(c) of the Health Insurance Portability

1 and Accountability Act of 1996 (42 U.S.C. 1320d-
2 2 note) and security standards established under
3 section 1173(d) of the Social Security Act.

4 “(2) STATE.—The term ‘State’ has the mean-
5 ing given such term when used in title XI of the So-
6 cial Security Act, as provided under section 1101(a)
7 of such Act (42 U.S.C. 1301(a)).

8 “(3) STATE SECURITY AND CONFIDENTIALITY
9 LAWS.—The term ‘State security and confidentiality
10 laws’ means State laws and regulations relating to
11 the privacy and confidentiality of health information
12 or to the security of such information.”.

13 **TITLE III—PROMOTING THE USE**
14 **OF HEALTH INFORMATION**
15 **TECHNOLOGY TO BETTER CO-**
16 **ORDINATE HEALTH CARE**

17 **SEC. 301. SAFE HARBORS TO ANTIKICKBACK CIVIL PEN-**
18 **ALTIES AND CRIMINAL PENALTIES FOR PRO-**
19 **VISION OF HEALTH INFORMATION TECH-**
20 **NOLOGY AND TRAINING SERVICES.**

21 (a) FOR CIVIL PENALTIES.—Section 1128A of the
22 Social Security Act (42 U.S.C. 1320a-7a) is amended—
23 (1) in subsection (b), by adding at the end the
24 following new paragraph:

1 “(4) For purposes of this subsection, inducements to
2 reduce or limit services described in paragraph (1) shall
3 not include the practical or other advantages resulting
4 from health information technology or related installation,
5 maintenance, support, or training services.”; and

6 (2) in subsection (i), by adding at the end the
7 following new paragraph:

8 “(8) The term ‘health information technology’
9 means hardware, software, license, right, intellectual
10 property, equipment, or other information tech-
11 nology (including new versions, upgrades, and
12 connectivity) designed or provided primarily for the
13 electronic creation, maintenance, or exchange of
14 health information to better coordinate care or im-
15 prove health care quality, efficiency, or research.”.

16 (b) FOR CRIMINAL PENALTIES.—Section 1128B of
17 such Act (42 U.S.C. 1320a-7b) is amended—

18 (1) in subsection (b)(3)—

19 (A) in subparagraph (G), by striking
20 “and” at the end;

21 (B) in the subparagraph (H) added by sec-
22 tion 237(d) of the Medicare Prescription Drug,
23 Improvement, and Modernization Act of 2003
24 (Public Law 108–173; 117 Stat. 2213)—

1 (i) by moving such subparagraph 2
2 ems to the left; and

3 (ii) by striking the period at the end
4 and inserting a semicolon;

5 (C) in the subparagraph (H) added by sec-
6 tion 431(a) of such Act (117 Stat. 2287)—

7 (i) by redesignating such subpara-
8 graph as subparagraph (I);

9 (ii) by moving such subparagraph 2
10 ems to the left; and

11 (iii) by striking the period at the end
12 and inserting “; and”; and

13 (D) by adding at the end the following new
14 subparagraph:

15 “(J) any nonmonetary remuneration (in the
16 form of health information technology, as defined in
17 section 1128A(i)(8), or related installation, mainte-
18 nance, support or training services) made to a per-
19 son by a specified entity (as defined in subsection
20 (g)) if—

21 “(i) the provision of such remuneration is
22 without an agreement between the parties or
23 legal condition that—

24 “(I) limits or restricts the use of the
25 health information technology to services

1 provided by the physician to individuals re-
2 ceiving services at the specified entity;

3 “(II) limits or restricts the use of the
4 health information technology in conjunc-
5 tion with other health information tech-
6 nology; or

7 “(III) conditions the provision of such
8 remuneration on the referral of patients or
9 business to the specified entity;

10 “(ii) such remuneration is arranged for in
11 a written agreement that is signed by the par-
12 ties involved (or their representatives) and that
13 specifies the remuneration solicited or received
14 (or offered or paid) and states that the provi-
15 sion of such remuneration is made for the pri-
16 mary purpose of better coordination of care or
17 improvement of health quality, efficiency, or re-
18 search; and

19 “(iii) the specified entity providing the re-
20 muneration (or a representative of such entity)
21 has not taken any action to disable any basic
22 feature of any hardware or software component
23 of such remuneration that would permit inter-
24 operability.”; and

1 (2) by adding at the end the following new sub-
2 section:

3 “(g) SPECIFIED ENTITY DEFINED.—For purposes of
4 subsection (b)(3)(J), the term ‘specified entity’—

5 “(1) means an entity that is a hospital, group
6 practice, prescription drug plan sponsor, a Medicare
7 Advantage organization, or any other such entity
8 specified by the Secretary, considering the goals and
9 objectives of this section, as well as the goals to bet-
10 ter coordinate the delivery of health care and to pro-
11 mote the adoption and use of health information
12 technology; and

13 “(2) includes, effective October 1, 2011, any
14 entity.”.

15 (c) EFFECTIVE DATE AND EFFECT ON STATE
16 LAWS.—

17 (1) EFFECTIVE DATE.—The amendments made
18 by subsections (a) and (b) shall take effect on the
19 date that is 120 days after the date of the enact-
20 ment of this Act.

21 (2) PREEMPTION OF STATE LAWS.—No State
22 (as defined in section 1101(a) of the Social Security
23 Act (42 U.S.C. 1301(a)) for purposes of title XI of
24 such Act) shall have in effect a State law that im-
25 poses a criminal or civil penalty for a transaction de-

1 scribed in section 1128A(b)(4) or section
2 1128B(b)(3)(J) of such Act, as added by subsections
3 (a)(1) and (b), respectively, if the conditions de-
4 scribed in the respective provision, with respect to
5 such transaction, are met.

6 (d) STUDY AND REPORT TO ASSESS EFFECT OF
7 SAFE HARBORS ON HEALTH SYSTEM.—

8 (1) IN GENERAL.—The Secretary of Health and
9 Human Services shall conduct a study to determine
10 the impact of each of the safe harbors described in
11 paragraph (3). In particular, the study shall examine
12 the following:

13 (A) The effectiveness of each safe harbor
14 in increasing the adoption of health information
15 technology.

16 (B) The types of health information tech-
17 nology provided under each safe harbor.

18 (C) The extent to which the financial or
19 other business relationships between providers
20 under each safe harbor have changed as a re-
21 sult of the safe harbor in a way that adversely
22 affects or benefits the health care system or
23 choices available to consumers.

1 (D) The impact of the adoption of health
2 information technology on health care quality,
3 cost, and access under each safe harbor.

4 (2) REPORT.—Not later than three years after
5 the effective date described in subsection (c)(1), the
6 Secretary of Health and Human Services shall sub-
7 mit to Congress a report on the study under para-
8 graph (1).

9 (3) SAFE HARBORS DESCRIBED.—For purposes
10 of paragraphs (1) and (2), the safe harbors de-
11 scribed in this paragraph are—

12 (A) the safe harbor under section
13 1128A(b)(4) of such Act (42 U.S.C. 1320a-
14 7a(b)(4)), as added by subsection (a)(1); and

15 (B) the safe harbor under section
16 1128B(b)(3)(J) of such Act (42 U.S.C. 1320a-
17 7b(b)(3)(J)), as added by subsection (b).

18 **SEC. 302. EXCEPTION TO LIMITATION ON CERTAIN PHYSI-**
19 **CIAN REFERRALS (UNDER STARK) FOR PRO-**
20 **VISION OF HEALTH INFORMATION TECH-**
21 **NOLOGY AND TRAINING SERVICES TO**
22 **HEALTH CARE PROFESSIONALS.**

23 (a) IN GENERAL.—Section 1877(b) of the Social Se-
24 curity Act (42 U.S.C. 1395nn(b)) is amended by adding
25 at the end the following new paragraph:

1 “(6) INFORMATION TECHNOLOGY AND TRAIN-
2 ING SERVICES.—

3 “(A) IN GENERAL.—Any nonmonetary re-
4 muneration (in the form of health information
5 technology or related installation, maintenance,
6 support or training services) made by a speci-
7 fied entity to a physician if—

8 “(i) the provision of such remunera-
9 tion is without an agreement between the
10 parties or legal condition that—

11 “(I) limits or restricts the use of
12 the health information technology to
13 services provided by the physician to
14 individuals receiving services at the
15 specified entity;

16 “(II) limits or restricts the use of
17 the health information technology in
18 conjunction with other health informa-
19 tion technology; or

20 “(III) conditions the provision of
21 such remuneration on the referral of
22 patients or business to the specified
23 entity;

24 “(ii) such remuneration is arranged
25 for in a written agreement that is signed

1 by the parties involved (or their represent-
2 atives) and that specifies the remuneration
3 made and states that the provision of such
4 remuneration is made for the primary pur-
5 pose of better coordination of care or im-
6 provement of health quality, efficiency, or
7 research; and

8 “(iii) the specified entity (or a rep-
9 resentative of such entity) has not taken
10 any action to disable any basic feature of
11 any hardware or software component of
12 such remuneration that would permit
13 interoperability.

14 “(B) HEALTH INFORMATION TECHNOLOGY
15 DEFINED.—For purposes of this paragraph, the
16 term ‘health information technology’ means
17 hardware, software, license, right, intellectual
18 property, equipment, or other information tech-
19 nology (including new versions, upgrades, and
20 connectivity) designed or provided primarily for
21 the electronic creation, maintenance, or ex-
22 change of health information to better coordi-
23 nate care or improve health care quality, effi-
24 ciency, or research.

1 “(C) SPECIFIED ENTITY DEFINED.—For
2 purposes of this paragraph, the term ‘specified
3 entity’—

4 “(i) means an entity that is a hos-
5 pital, group practice, prescription drug
6 plan sponsor, a Medicare Advantage orga-
7 nization, or any other such entity specified
8 by the Secretary, considering the goals and
9 objectives of this section, as well as the
10 goals to better coordinate the delivery of
11 health care and to promote the adoption
12 and use of health information technology;
13 and

14 “(ii) includes, effective October 1,
15 2011, any entity.”.

16 (b) EFFECTIVE DATE; EFFECT ON STATE LAWS.—

17 (1) EFFECTIVE DATE.—The amendment made
18 by subsection (a) shall take effect on the date that
19 is 120 days after the date of the enactment of this
20 Act.

21 (2) PREEMPTION OF STATE LAWS.—No State
22 (as defined in section 1101(a) of the Social Security
23 Act (42 U.S.C. 1301(a)) for purposes of title XI of
24 such Act) shall have in effect a State law that im-
25 poses a criminal or civil penalty for a transaction de-

1 scribed in section 1877(b)(6) of such Act, as added
2 by subsection (a), if the conditions described in such
3 section, with respect to such transaction, are met.

4 (c) STUDY AND REPORT TO ASSESS EFFECT OF EX-
5 CEPTION ON HEALTH SYSTEM.—

6 (1) IN GENERAL.—The Secretary of Health and
7 Human Services shall conduct a study to determine
8 the impact of the exception under section 1877(b)(6)
9 of such Act (42 U.S.C. 1395nn(b)(6)), as added by
10 subsection (a). In particular, the study shall examine
11 the following:

12 (A) The effectiveness of the exception in
13 increasing the adoption of health information
14 technology.

15 (B) The types of health information tech-
16 nology provided under the exception.

17 (C) The extent to which the financial or
18 other business relationships between providers
19 under the exception have changed as a result of
20 the exception in a way that adversely affects or
21 benefits the health care system or choices avail-
22 able to consumers.

23 (D) The impact of the adoption of health
24 information technology on health care quality,
25 cost, and access under the exception.

1 (2) REPORT.—Not later than three years after
2 the effective date described in subsection (b)(1), the
3 Secretary of Health and Human Services shall sub-
4 mit to Congress a report on the study under para-
5 graph (1).

6 **SEC. 303. RULES OF CONSTRUCTION REGARDING USE OF**
7 **CONSORTIA.**

8 (a) APPLICATION TO SAFE HARBOR FROM CRIMINAL
9 PENALTIES.—Section 1128B(b)(3) of the Social Security
10 Act (42 U.S.C. 1320a-7b(b)(3)) is amended by adding
11 after and below subparagraph (J), as added by section
12 301(b)(1), the following:“For purposes of subparagraph
13 (J), nothing in such subparagraph shall be construed as
14 preventing a specified entity, consistent with the specific
15 requirements of such subparagraph, from forming a con-
16 sortium composed of health care providers, payers, em-
17 ployers, and other interested entities to collectively pur-
18 chase and donate health information technology, or from
19 offering health care providers a choice of health informa-
20 tion technology products in order to take into account the
21 varying needs of such providers receiving such products.”.

22 (b) APPLICATION TO STARK EXCEPTION.—Para-
23 graph (6) of section 1877(b) of the Social Security Act
24 (42 U.S.C. 1395nn(b)), as added by section 302(a), is

1 amended by adding at the end the following new subpara-
2 graph:

3 “(D) RULE OF CONSTRUCTION.—For pur-
4 poses of subparagraph (A), nothing in such
5 subparagraph shall be construed as preventing
6 a specified entity, consistent with the specific
7 requirements of such subparagraph, from—

8 “(i) forming a consortium composed
9 of health care providers, payers, employers,
10 and other interested entities to collectively
11 purchase and donate health information
12 technology; or

13 “(ii) offering health care providers a
14 choice of health information technology
15 products in order to take into account the
16 varying needs of such providers receiving
17 such products.”.

18 **TITLE IV—ADDITIONAL**
19 **PROVISIONS**

20 **SEC. 401. PROMOTION OF TELEHEALTH SERVICES.**

21 (a) FACILITATING THE PROVISION OF TELEHEALTH
22 SERVICES ACROSS STATE LINES.—The Secretary of
23 Health and Human Services shall, in coordination with
24 physicians, health care practitioners, patient advocates,
25 and representatives of States, encourage and facilitate the

1 adoption of State reciprocity agreements for practitioner
2 licensure in order to expedite the provision across State
3 lines of telehealth services.

4 (b) REPORT.—Not later than 18 months after the
5 date of the enactment of this Act, the Secretary of Health
6 and Human Services shall submit to Congress a report
7 on the actions taken to carry out subsection (a).

8 (c) STATE DEFINED.—For purposes of this sub-
9 section, the term “State” has the meaning given that term
10 for purposes of title XVIII of the Social Security Act.

11 **SEC. 402. STUDY AND REPORT ON EXPANSION OF HOME**
12 **HEALTH-RELATED TELEHEALTH SERVICES.**

13 (a) STUDY.—The Secretary of Health and Human
14 Services shall conduct a study to determine the feasibility,
15 advisability, and the costs of—

16 (1) including coverage and payment for home
17 health-related telehealth services as part of home
18 health services under title XVIII of the Social Secu-
19 rity Act; and

20 (2) expanding the list of sites described in para-
21 graph (4)(C)(ii) of section 1834(m) of the Social Se-
22 curity Act (42 U.S.C. 1395m(m)) to include county
23 mental health clinics or other publicly funded mental
24 health facilities for the purpose of payment under

1 such section for the provision of telehealth services
2 at such clinics or facilities.

3 (b) SPECIFICS OF STUDY.—Such study shall dem-
4 onstrate whether the changes described in paragraphs (1)
5 and (2) of subsection (a) will result in the following:

6 (1) Enhanced health outcomes for individuals
7 with one or more chronic conditions.

8 (2) Health outcomes for individuals furnished
9 telehealth services or home health-related telehealth
10 services that are at least comparable to the health
11 outcomes for individuals furnished similar items and
12 services by a health care provider at the same loca-
13 tion of the individual or at the home of the indi-
14 vidual, respectively.

15 (3) Facilitation of communication of more accu-
16 rate clinical information between health care pro-
17 viders.

18 (4) Closer monitoring of individuals by health
19 care providers.

20 (5) Overall reduction in expenditures for health
21 care items and services.

22 (6) Improved access to health care.

23 (c) HOME HEALTH-RELATED TELEHEALTH SERV-
24 ICES DEFINED.—For purposes of this section, the term
25 “home health-related telehealth services” means tech-

1 nology-based professional consultations, patient moni-
2 toring, patient training services, clinical observation, pa-
3 tient assessment, and any other health services that utilize
4 telecommunications technologies. Such term does not in-
5 clude a telecommunication that consists solely of a tele-
6 phone audio conversation, facsimile, electronic text mail,
7 or consultation between two health care providers.

8 (d) REPORT.—Not later than 18 months after the
9 date of the enactment of this Act, the Secretary of Health
10 and Human Services shall submit to Congress a report
11 on the study conducted under subsection (a) and shall in-
12 clude in such report such recommendations for legislation
13 or administration action as the Secretary determines ap-
14 propriate.

15 **SEC. 403. STUDY AND REPORT ON STORE AND FORWARD**
16 **TECHNOLOGY FOR TELEHEALTH.**

17 (a) STUDY.—The Secretary of Health and Human
18 Services, acting through the Director of the Office for the
19 Advancement of Telehealth, shall conduct a study on the
20 use of store and forward technologies (that provide for the
21 asynchronous transmission of health care information in
22 single or multimedia formats) in the provision of tele-
23 health services. Such study shall include an assessment of
24 the feasibility, advisability, and the costs of expanding the

1 use of such technologies for use in the diagnosis and treat-
2 ment of certain conditions.

3 (b) REPORT.—Not later than 18 months after the
4 date of the enactment of this Act, the Secretary of Health
5 and Human Services shall submit to Congress a report
6 on the study conducted under subsection (a) and shall in-
7 clude in such report such recommendations for legislation
8 or administration action as the Secretary determines ap-
9 propriate.

10 **SEC. 404. METHODOLOGY FOR REPORTING UNIFORM PRICE**

11 **DATA FOR INPATIENT AND OUTPATIENT HOS-**

12 **PITAL SERVICES.**

13 (a) IN GENERAL.—The Secretary of Health and
14 Human Services shall develop a method for the reporting
15 of uniform price data for inpatient and outpatient hospital
16 services. Such method shall provide for the reporting by
17 each hospital of such data for selected procedures or serv-
18 ices based on a range of charges and a range of prices
19 actually paid for inpatient and outpatient hospital services
20 grouped by type of payer, with each of the following treat-
21 ed as a separate type of payer: the Medicare program, the
22 Medicaid program, other public health insurance coverage
23 (including public group health plan coverage), private
24 health insurance coverage (including private group health
25 plan coverage), other insurance coverage, and self-pay.

1 (b) GAO STUDY AND REPORT.—

2 (1) STUDY.—The Comptroller General of the
3 United States shall conduct a study to assess the
4 structure and methodology for permanent uniform
5 reporting of price data for health care services.

6 (2) REPORT.—Not later than January 1, 2008,
7 the Comptroller General shall submit to Congress a
8 report on the study under paragraph (1). Such re-
9 port shall include the following:

10 (A) Recommendations on a structure and
11 methodology, for timely reporting of charges
12 and prices actually paid for health care services,
13 that minimize administrative requirements for
14 providers and maximize efficient reporting uti-
15 lizing health information technology.

16 (B) Options for facilitating public disclo-
17 sure of such information in a manner accessible
18 and useful to consumers.

19 (C) Review of the strengths and weak-
20 nesses of the reporting requirements imposed
21 beginning with fiscal year 2008 under section
22 405.

23 **SEC. 405. INCLUSION OF UNIFORM PRICE DATA.**

24 Data required to be submitted pursuant to section
25 1886(b)(3)(B)(viii) of the Social Security Act (42 U.S.C.

1 1395ww(b)(3)(B)(viii)) shall include, effective with fiscal
2 year 2008, the data described in section 404(a), with re-
3 spect to inpatient hospital services, submitted in accord-
4 ance with the method developed under such section, as
5 well as the aggregate volume of selected procedures or
6 services for which the data are reported.

7 **SEC. 406. ENSURING HEALTH CARE PROVIDERS PARTICI-**
8 **PATING IN PHSA PROGRAMS, MEDICAID,**
9 **SCHIP, OR THE MCH PROGRAM MAY MAIN-**
10 **TAIN HEALTH INFORMATION IN ELECTRONIC**
11 **FORM.**

12 Part D of title II of the Public Health Service Act,
13 as added by section 101(a) and amended by sections 103
14 and 105, is further amended by adding at the end the
15 following new section:

16 **“SEC. 274. ENSURING HEALTH CARE PROVIDERS MAY MAIN-**
17 **TAIN HEALTH INFORMATION IN ELECTRONIC**
18 **FORM.**

19 “(a) IN GENERAL.—Any health care provider that
20 participates in a health care program that receives Federal
21 funds under this Act, or under title V, XIX, or XXI of
22 the Social Security Act, shall be deemed as meeting any
23 requirement for the maintenance of data in paper form
24 under such program (whether or not for purposes of man-

1 agement, billing, reporting, reimbursement, or otherwise)
2 if the required data is maintained in an electronic form.

3 “(b) RELATION TO STATE LAWS.—Beginning on the
4 date that is one year after the date of the enactment of
5 this section, subsection (a) shall supersede any contrary
6 provision of State law.

7 “(c) CONSTRUCTION.—Nothing in this section shall
8 be construed as—

9 “(1) requiring health care providers to maintain
10 or submit data in electronic form;

11 “(2) preventing a State from permitting health
12 care providers to maintain or submit data in paper
13 form; or

14 “(3) preventing a State from requiring health
15 care providers to maintain or submit data in elec-
16 tronic form.”.

17 **SEC. 407. ENSURING HEALTH CARE PROVIDERS PARTICI-**
18 **PATING IN THE MEDICARE PROGRAM MAY**
19 **MAINTAIN HEALTH INFORMATION IN ELEC-**
20 **TRONIC FORM.**

21 Section 1871 of the Social Security Act (42 U.S.C.
22 1395hh) is amended by adding at the end the following
23 new subsection:

24 “(g)(1) Any provider of services or supplier shall be
25 deemed as meeting any requirement for the maintenance

1 of data in paper form under this title (whether or not for
2 purposes of management, billing, reporting, reimburse-
3 ment, or otherwise) if the required data is maintained in
4 an electronic form.

5 “(2) Nothing in this subsection shall be construed as
6 requiring health care providers to maintain or submit data
7 in electronic form.”.

8 **SEC. 408. STUDY AND REPORT ON STATE, REGIONAL, AND**
9 **COMMUNITY HEALTH INFORMATION EX-**
10 **CHANGES.**

11 (a) STUDY.—The Secretary of Health and Human
12 Services shall conduct a study on issues related to the de-
13 velopment, operation, and implementation of State, re-
14 gional, and community health information exchanges.
15 Such study shall include the following, with respect to
16 such health information exchanges:

17 (1) Profiles detailing the current stages of such
18 health information exchanges with respect to the
19 progression of the development, operation, imple-
20 mentation, organization, and governance of such ex-
21 changes.

22 (2) The impact of such exchanges on healthcare
23 quality, safety, and efficiency, including—

24 (A) any impact on the coordination of
25 health information and services across

1 healthcare providers and other organizations
2 relevant to health care;

3 (B) any impact on the availability of health
4 information at the point-of-care to make timely
5 medical decisions;

6 (C) any benefits with respect to the pro-
7 motion of wellness, disease prevention, and
8 chronic disease management;

9 (D) any improvement with respect to pub-
10 lic health preparedness and response;

11 (E) any impact on the widespread adoption
12 of interoperable health information technology,
13 including electronic health records;

14 (F) any contributions to achieving an
15 Internet-based national health information net-
16 work;

17 (G) any contribution of health information
18 exchanges to consumer access and to con-
19 sumers' use of their health information; and

20 (H) any impact on the operation of—

21 (i) the Medicaid and Medicare pro-
22 grams;

23 (ii) the State Children's Health Insur-
24 ance Program (SCHIP);

1 (iii) disproportionate share hospitals
2 described in section 1923 of the Social Se-
3 curity Act;

4 (iv) Federally-qualified health centers;
5 or

6 (v) managed care plans, if a signifi-
7 cant number of the plan's enrollees are
8 beneficiaries in the Medicaid program or
9 SCHIP.

10 (3) Best practice models for financing,
11 incentivizing, and sustaining such health information
12 exchanges.

13 (4) Information identifying the common prin-
14 ciples, policies, tools, and standards used (or pro-
15 posed) in the public and private sectors to support
16 the development, operation, and implementation of
17 such health information exchanges.

18 (5) A description of any areas in which Federal
19 government leadership is needed to support growth
20 and sustainability of such health information ex-
21 changes.

22 (b) REPORT.—Not later than one year after the date
23 of enactment of this Act, the Secretary of Health and
24 Human Services shall submit to Congress a report on the
25 study described in subsection (a), including such rec-

- 1 ommendations as the Secretary determines appropriate to
- 2 facilitate the development, operation, and implementation
- 3 of health information exchanges.

Amend the title so as to read: “A Bill to promote
a better health information system.”.